Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
EDWARD WOLSKI MD
2436 E IH-35 SOUTH NO 336
DENTON TX 76205

Carrier's Austin Representative Box
19

MFDR Date Received
March 2, 2012

Respondent Name
Acadia Insurance Co

MFDR Tracking Number
M4-12-2257-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauthorization was obtained from the insurance carrier for 90862. Our services were billed in a timely manner. The carrier denied payment for 90862, stating the service was not medically necessary. Medical necessity was determined at the time of preauthorization. "

Amount in Dispute: $81.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier submits the treatment offered was for a non-compensable condition."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
March 24, 2011	90862	$81.24	$81.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code, §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §133.20 sets out medical bill submission requirements for health care providers
3. 28 Texas Administrative Code §134.203 sets out guidelines for professional medical services
4. 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of health care
5. 28 Texas Administrative Code §133.240 sets out guidelines for medical payment and denials
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 216 – BASED ON THE FINDINGS OF A REVIEW ORGANIZATION
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.

Issues

1. Did the respondent raise a new denial reason?
2. Is the service in dispute included in the value of another service/procedure?
3. Was Explanation of Benefits dated January 18, 2012 in compliance with 133.240?
4. Is the requestor entitled to additional reimbursement?

Findings

1. In its response to medical fee dispute resolution, the respondent states that "The carrier submits the treatment offered was for a non-compensable condition." Applicable 28 Texas Administrative Code §133.307 (d)(2)(B) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented this denial reason prior to the request for MFDR for the service in dispute code 90862. This code was authorized by Forte on March 23, 2011 specifically, "AUTHORIZATION OP Medication Management x2 sessions as related to the lumbar spine (1 visit every 3 months for 6 months).The division concludes that the carrier raised a new denial reason. For that reason, the carrier's position regarding non-compensable condition shall not be considered in this review.

2. 28 Texas Administrative Code §134.600 states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: … B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; The service in dispute was denied, in part, due to 216 – "BASED ON THE FINDINGS OF A REVIEW ORGANIZATION." The division finds the "NON-AUTHORIZATION" as requested was for "OP Medication Management x 4 sessions as related to the lumbar spine (1 visit every 3 months for 12 months). However, as stated above authorization was given for 2 visits 1 visit every 3 months for 6 months. Reimbursement is recommended.

3. 28 Texas Administrative Code §134.240(17)(f)(G) states "adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;" Notation that specifically mentions "Billing unrelated to Workers' Compensation diagnosis" does not conform to TAC 133.500 and 133.501. Therefore, only the valid remittance code 193 has been considered.

4. The total reimbursement for 90862 may be determined using division rule 28 TAC §134.203 (c)(1) which states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications…(1) For service categories of Evaluation & Management, General Medicine…" The service in dispute is found in the general medicine section of the AMA CPT code book; therefore the maximum allowable reimbursement (MAR) = (TDI-DWC Medicine Conversion Factor / Medicare conversion factor) x Medicare Price *or* ($54.54 / 33.9764) x $61.51 = $98.74. The amount in dispute is $81.24; this amount is recommended for payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $81.24.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $110.27 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 21, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.